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Issue Date: 29 July 2004

CASE NO.: 2003-LHC-2234
OWCP NO.: 06-187815

In the Matter of:

GARY KING,
Claimant,

v.

IMC GLOBAL,
Employer,

and

TRAVELERS PROPERTY & CASUALTY CORP.,
Carrier.

Appearances: Anthony V. Cortese, Esq.
For the Claimant

William C. Cruse, Esq.
For the Employer

Before: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim under the Longshore and Harbor Workers' Compensation Act ("Act" or "LHWCA"), 33 U.S.C. § 901 *et seq*. Claimant is seeking disability and medical benefits relating to work-related injuries to his low back, neck, and right leg on February 8, 2002.

A formal hearing was held in this case on October 20, 2003 in Orlando, Florida at which both parties were afforded a full opportunity to present evidence and argument as provided by law and applicable regulation. Claimant offered exhibits 1 through 20 which were admitted into

evidence.[1] Employer offered exhibits 1 through 16 which were admitted into evidence. ALJX[2] 1 through 2 were marked for identification and admitted into evidence without objection. Both parties filed post-hearing briefs. The findings and conclusions which follow are based on a complete review of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent precedent.

I. STIPULATIONS

The parties have stipulated (Tr. 21; ALJX 2; Cl. Br. at 16; Emp. Br. at 2) and I find:

1. That the parties are subject to the Act.
2. That Claimant and Employer were in an employee-employer relationship at all relevant times.
3. That Claimant sustained an injury to his back and right ankle arising out of and in the course of his employment on February 8, 2002 at Port Sutton, Tampa, Florida.
4. That a timely notice of injury was given by Claimant to Employer on February 8, 2002.
5. That Claimant filed a timely claim for compensation on November 6, 2002.
6. That Employer filed a timely first report of injury.
7. That there has been voluntary payment of some medical benefits and temporary total disability compensation by Employer from July 29, 2002 to November 21, 2002[3] at a rate of $402.13 per week for a total of $6,663.84.
8. That Claimant's average weekly wage at the time of the injury was $675.84.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Causation of Claimant's alleged cervical spine injury.
2. The nature and extent of Claimant's disability.
3. Employer's liability for various medical expenses.

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[1] Both parties filed motions *in limine* just before the formal hearing with respect to certain exhibits being offered by the opposing party. Since Claimant's motions had not been seen by me before leaving Washington, D.C. to travel to Orlando for the hearing, ruling on the motions was reserved until Employer had an opportunity to file a written responses and I could fully considered the matters raised therein after the hearing. The admission of Employer's exhibits was thus conditioned on my subsequent ruling on the motion. A motion *in limine* filed by Employer to exclude the report and testimony of Dr. Baker was denied at the time of the hearing. *See* Tr. 16-21.

[2] The following abbreviations will be used as citations to the record: "CX" for Claimant's Exhibits, "EX" for Employer's Exhibits, "ALJX" for Administrative Law Judge Exhibits, and "Tr." for Transcript. In addition, the parties' post-hearing briefs will be referenced as "Cl. Br." for Closing Statement and Trial Memorandum of Claimant, Gary King, and "Emp. Br." for Employer's Post-Trial Brief.

[3] The stipulation form signed by counsel reflects dates of voluntary disability compensation payments from July 29, 2002 to November 4, 2002. ALJX 2. However, an LS-208 "Notice of Final Payment or Suspension of Compensation Payments" form filed by Employer notes that temporary total disability payments were actually made from July 29, 2002 to November 21, 2002. EX 2 a 3.

III. CLAIMANT'S MOTIONS IN LIMINE

As noted above, Claimant filed on the eve of the formal hearing several pre-trial motions seeking to exclude certain items of Employer's evidence. The motions were received by the Office of Administrative Law Judges in Washington, D.C. and docketed on Friday, October 17, 2003 after 5:30 p.m. They were not seen by me prior to the formal hearing in Orlando, Florida on Monday morning, October 20, 2003. Consequently, the parties were advised that I would reserve ruling on the motions until such time as Employer was given the opportunity to respond to the motions and I could review and consider the motions and responses. Tr. 6-15. At the end of the hearing, Claimant's counsel withdrew his motions to preclude evidence and defenses based on Employer's failure to file a pre-trial statement and to exclude surveillance evidence. Tr. 163. On November 12, 2003, Employer filed its opposition to Claimant's remaining motions. On November 12, 2003, Claimant filed a reply only with respect to Employer's opposition to his motion to exclude the report and testimony of Dr. Johnson.

Motion to Exclude Testimony and Reports of Dr. Finn.

Claimant seeks to have the report of Charles A. Finn, M.D. (EX 8) and his testimony (EX 14) excluded from the record in this matter. He alleges that Dr. Finn was retained by Employer for the sole purpose of obtaining a second opinion on the injury of Claimant and that medical records provided to him by Employer's agent before he examined Claimant were destroyed by Dr. Finn at the request of Employer. Motion to Exclude Testimony and Reports of Dr. Finn, the Employer/Carrier's Expert Witness ("Finn Mot.") at 1-2. According to Claimant, Dr. Finn testified at his deposition that he had no recollection of what medical records he reviewed when he examined Claimant and prepared a written report of his findings, and Dr. Finn's failure to recall what records he reviewed has deprived Claimant of the ability to effectively cross examine him regarding contradictions between his opinions and the opinions of other doctors contained in those records. *Id*. at 2. Claimant relies on Florida and Federal Rules of Evidence pertaining to the admissibility of expert opinions as authority for excluding this evidence. *Id*. at 2-5.

Dr. Finn was deposed for one and one-half hours on October 6, 2003. EX 14. Documents contained in his file relating to Claimant reflect that he was asked to conduct an Independent Medical Examination ("IME") on behalf of Employer/Carrier on Wednesday, August 28, 2002, and that records provided to Dr. Finn by Concentra Medical Examinations (Employer/Carrier's agent) were to be destroyed after his examination was completed rather than returned to Concentra. *Id*. at 46, 48.

Dr. Finn testified that it was his standard practice not to retain records sent to him prior to conducting IMEs, but rather to return those records to the insurance company which provided them or, if they so requested, to destroy them. *Id*. at 6. He stated:

> Well, generally my office manager asks "What do you want us to do with these records? Do you want us to send them back or do you want us to destroy them?" And they [Concentra] had indicated to destroy them.

Id. at 8.

The only reference to records reviewed by Dr. Finn given in the IME report is:

> I have no diagnostic studies to review. He has had MRI scanning and plain films. I have reviewed all the medical records provided including notes from the physical therapist, notes from HealthSouth, and the medicals that have been provided, as well as from the walk-in clinic.

EX 8 at 3. When questioned about whether he had reviewed specific treatment records, Dr. Finn generally testified that he had no independent recollection of what those records were. *See, e.g.*, EX 14 at 11-12. Claimant, however, had a full opportunity to question Dr. Finn about specific findings reflected in records that appeared to conflict with Dr. Finn's conclusion that Claimant's problems had resolved. For example, when asked if he would change his opinion based on findings of spasm and limited range of motion in the lumbar and cervical spine noted in records generated by Claimant's treating physician prior to the IME, Dr. Finn testified:

> No, it wouldn't change my opinion one bit. On the day of August 28, 2002, he had full unrestricted range of motion of the cervical, thoracic and lumbar spine. And more important than even those documentations and records, the MRI [report dated March 29, 2002 which] was sent just showed preexisting spinal stenosis, which is a preexisting condition and would be unrelated to any trauma. So they wouldn't change my opinion a bit.

EX 14 at 13-14. When asked if he was aware that Dr. Dave believed Claimant had a herniated disc in his low back, Dr. Finn testified:

> I am not aware that Dr. Dave thought that there was a herniation in the low back. But the MRI report did not – the report that I reviewed did not reveal any herniated disk. And I can tell you as a fellowship-trained spine surgeon, he had no symptoms of a herniated disk in his back on August 28, 2002, whatsoever.

Id. at 16. He further testified that additional testing, such as a repeat MRI with contrast, or electrical testing and evaluation by a neurologist were neither reasonable nor indicated given the lack of any symptoms of radiculopathy displayed by Claimant at the time of the examination. *Id*. at 16-17. When questioned by Employer's counsel regarding the basis for his medical conclusions, Dr. Finn testified, in relevant part:

> I am basing my opinions on that day that I examined the patient. And people with radiculopathy and people with disk pathology, they can have their good days and bad days, but they just don't come in with a full, full complete normal examination as this gentleman did. And then given the fact that his MRI scan showed the results that it showed, it wouldn't change – if there was ten stacks of medical records that said that epidurals were necessary or electrodiagnostic studies were necessary or further MRIs with contrast, which is absolutely ridiculous, is necessary, that would not change any of my opinions in this

particular instance based on his examination and based on the findings of that MRI.

Id. at 20-21.

After having reviewed the transcript of Dr. Finn's deposition, I find that Claimant was not deprived of his right to cross-examine Employer's expert. While Dr. Finn clearly no longer had in his possession certain records that he had reviewed in formulating his opinion, Claimant's argument goes more to the weight which should be accorded Dr. Finn's opinion rather than its admissibility. Although he asserts he could not effectively cross-examine Dr. Finn without the medical records provided by Concentra, Claimant ignores the fact that Dr. Finn had an independent basis for formulating an opinion regarding Claimant's condition irrespective of the records provided by Concentra. Dr. Finn met with Claimant on August 28, 2002, obtained family and medical histories and a description of Claimant's injuries, and he physically examined Claimant. EX 8. The examination conducted by Dr. Finn reflected, *inter alia*, "full and unrestricted range of motion of the cervical, thoracic, and lumbar spine . . . [and] no motor, sensory, or reflex[] deficits in the upper extremities and lower extremities in all major muscles and dermatomes testing." *Id*. at 2. He further noted "[n]o pain with range of motion of the hips, knees, and ankles . . . [and [f]ull and unrestricted range of motion of the hips, knees, and ankles with no deficits in his lower extremities whatsoever." *Id*. at 3. Based on the results of his examination, he concluded that Claimant's neck, back, knee, and ankle injuries had resolved. *Ibid*. Furthermore, Dr. Finn expressly recalled reviewing the March 29, 2002 report of an MRI which showed only mild foraminal stenosis. EX 14 at 14. Under the circumstances presented here, I find that Dr. Finn's report and testimony are admissible.

Motion to Exclude Testimony and Evidence of Dr. Johnson.

Claimant next seeks to exclude the testimony and a medical report of Richard Johnson, M.D. (EX 9, EX 16). *See* Motion in Limine Regarding Testimony and Evidence of Dr. Johnson ("John. Mot."). Claimant first alleges that Employer failed to "forward any expert reports or C.V.'s [of Dr. Johnson] by August 22, 2003, the date that the expert reports were to be submitted."[4] *Id*. at 1. Claimant also contends that Dr. Johnson's pre-hearing deposition testimony should be excluded based on the fact that he did not have with him at the deposition all relevant medical records reflecting treatment of Claimant, thus limiting Claimant's ability to cross examine him. *Id*. at 2. Finally, Claimant seeks exclusion of this evidence because Employer's counsel had an *ex parte* communication with Dr. Johnson one week before the deposition which is, he asserts, contrary to Florida and Federal law. Claimant thus argues that, to the extent Dr. Johnson gave testimony as an overall expert, his testimony must be excluded other than as a treating physician. *Id*. at 4.

In response to Claimant's motion *in limine*, Employer states that it "forwarded all medical records [from Dr. Johnson] in response to discovery in March 2003, these medicals included the reports and records of Dr. Johnson. IMC additionally produced the medicals once again during the 30(b)(6) deposition of IMC." Memorandum in Opposition to Motion *In Limine*

[4] The date upon which expert reports were to be exchanged was August 25, 2003, not, as Claimant argued, August 22, 2003. Tr. 19.

Regarding Testimony and Evidence of Dr. Johnson ("John. Opp.") at 2. Employer further notes that Dr. Johnson was deposed prior to the formal hearing and Claimant had ample opportunity to cross-examine him with respect to his opinions in this case. *Id*. at 2-3. With respect to Claimant's assertion that Dr. Johnson's deposition testimony should be excluded because of an *ex parte* communication with Employer's counsel, Employer cites, *inter alia*, cases stating that the physician-patient privilege has no application to extrajudicial disclosures during informal discussions between defense counsel and a treating physician, and permitting *ex parte* communications with fact witnesses, such as a plaintiff's treating physician, furthers the requirement that the rules of civil procedure be construed so as to allow a just, speedy, and inexpensive determination in all cases. *Id*. at 4.

On November 12, 2003, Claimant filed a reply to Employer's opposition to his motion. Claimant argued that Dr. Johnson saw Claimant on only one occasion, May 30, 2002, but he was treated at Lakeside Medical Center, where Dr. Johnson practices, on several occasions. Dr. Johnson did not, according to Claimant, have all treatment records with him at his deposition, and Claimant's ability to cross-examine him was therefore limited. Claimant further notes that the Health Insurance Portability and Accountability Act ("HIPAA") became effective on April 14, 2003, prior to Employer's *ex parte* contact with Dr. Johnson in October 2003, and the limited release signed by Claimant in this case expressly precluded any verbal communications with treatment providers. Cl. Rep. at 2-3. Thus, according to Claimant, Employer's contact with Dr. Johnson violated HIPPA and his deposition testimony should be excluded.

Based on Employer's failure to identify Dr. Johnson as an expert witness in this proceeding at any time prior to his deposition on October 15, 2003, only five days before the formal hearing, I grant Claimant's motion to exclude records and testimony of Dr. Johnson other than those relating to his treatment of Claimant on May 30, 2002.[5]

Dr. Johnson was first tendered as an expert in the field of occupational medicine when he was deposed by Employer's counsel on October 15, 2003. EX 16 at 8. Claimant's attorney objected at that time to Dr. Johnson testifying as an expert in light of the fact that there had been no prior notice by Employer that it intended to use him as anything other than a treating physician. *Id*. at 21; *see also* Tr. 7-8.

In its opposition to Claimant's motion, Employer first challenges Claimant's assertion that Dr. Johnson's only involvement in this case was his treatment of Claimant on May 30, 2002. It asserts:

> This is patently untrue as Claimant received a copy of the medicals, including those of Dr. Johnson, in response to discovery in March 2003. Claimant's own motion proves up this fallacy as in paragraph 7, Claimant's counsel states "there were release to work notes that the Employer had produced in discovery from Lakeside Medical Center".

[5] Dr. Johnson's disposition testimony is found in EX 16, and a variety of documents, most of which are treatment records from Lakeside, are attached to the deposition transcript. Based on my ruling on Claimant's motion, testimony by Dr. Johnson as an occupational medicine expert is not considered. The testimony and records contained in EX 16 specifically relating to treatment of Claimant, however, are not excluded and will be considered.

Opp. to Mot. 3. However, the only Lakeside Medical Center records contained in Employer's exhibits are consistent with Claimant's assertion. Those records reflect treatment by Dr. Riscile on March 22, 2002, Dr. Kasper on April 17, 2002, Dr. Riscile again on May 16, 2002, and Ms. Welch (a Nurse Practitioner) on June 4, 2002. EX 9. The *only* treatment by Dr. Johnson reflected in those records is, as Claimant asserts, that which occurred on May 30, 2002. *Id*. at 5.

Employer's further assertion that Dr. Johnson's entire deposition testimony should be admitted since Claimant's counsel attended the deposition and had a full opportunity to cross-examine him is also unpersuasive. The prehearing order issued by me is this case required that experts be identified, and their reports exchanged, on or before August 25, 2003. Dr. Johnson was never identified by Employer before that date as an expert witness who would testify in this matter. The prehearing order further required that two weeks before the date of the hearing the parties exchange, *inter alia*, witness lists which specifically designated expert witnesses and included a brief statement concerning their field of expertise and proposed testimony. The witness list filed by Employer on October 7, 2003 neglects to identify *any* expert witnesses. The only reference to Dr. Johnson in the witness list is as follows:

> 6. Any and all *treating* physicians who treated claimant both prior to and subsequent to the work-related injury, including, but not limited to:
>
> a. Dr. Charles Finn
> b. *Dr. Richard Johnson*
> c. Dr. Naresh Dave
> d. Dr. Charles Domson, MRI Park Place

Employer's Witness and Exhibit Lists at 2 (italics added). A supplemental witness list filed by Employer on October 16, 2003 makes no reference to Dr. Johnson.

The Board has interpreted Section 27(a) of the LHWCA to include the power of an administrative law judge to exclude evidence offered in violation of a pre-hearing order. *Durham v. Embassy Dairy*, 19 BRBS 105, 108 (1986) (may exclude even relevant and material testimony for failure to comply with terms of prehearing order); *Williams v. Marine Terminals Corp.*, 14 BRBS 728, 733 (1981). Pre-hearing orders facilitate the conduct of a hearing: they provide the parties advance opportunities to prepare arguments, raise issues, and seek discovery. *Williams*, 14 BRBS at 733.

Given Employer's failure to comply with the requirements of the prehearing order issued in this case, and Claimant's lack of knowledge that Employer intended to rely on Dr. Johnson as an expert in occupational medicine until October 15, 2003, only days before the formal hearing, exclusion of any testimony other than that which pertains to his treatment of Claimant is appropriate.

In light of this ruling, it is not necessary to address Claimant's arguments based on Dr. Johnson's failure to have all records from Lakeside Medical Center with him at the deposition or the *ex parte* contact with Dr. Johnson by Employer's counsel one week prior to the deposition.

However, I note with respect to the first argument, Dr. Johnson did have with him the treatment records relating to Claimant's visits to Lakeside, including the May 30, 2002 visit, and Claimant had ample opportunity to cross-examine him regarding treatment during those specific visits. With respect to the *ex parte* contact by Employer's attorney, Claimant's concern in this regard was clearly premised on counsel's ability to "prepare" Dr. Johnson's testimony as an expert when he was deposed. According to Claimant's motion:

> The ex parte communication and failure to file an expert report with the pre-trial are prejudicial for two reasons. One reason is that the doctor's testimony in his deposition on direct was much broader than was contained in his medical record for May 30, 2003. The doctor's opinion and testimony covered all aspects of the case and there was no notice by expert report on August 22, 2003 [sic] that Dr. Johnson would be used in that manner. Moreover, it was obvious that counsel had planned his deposition with the doctor in the fact that defense counsel led the doctor, question by question, through most of the testimony with the doctor simply saying "yes" in response to long technical questions by defense counsel. Not only were the questions extremely leading which is not appropriate when questioning your own expert on direct, but they were very technical and obviously had been discussed and planned out in advance which would not be appropriate if the doctor is viewed as a treating physician because they were based on ex parte communications.

John. Mot. at 3. Given the limited admissibility of Dr. Johnson's testimony, the *ex parte* contact between Employer's counsel and Dr. Johnson is no longer significant.[6]

Motion to Exclude Letter from Dr. Naresh Dave.

Claimant next seeks to exclude a letter authored by Dr. Naresh Dave, an orthopedic surgeon who was treating Claimant for injuries associated with his February 2002 accident (EX 10 at 10). Motion for Exclusion of Letter of Dr. Dave to I.M.C. Representative ("Dave Mot."), Exhibit D. He asserts:

> On or about December 5, 2002, Dr. Dave wrote a letter to the representative of the Carrier . . . [which] indicated first that he did not know why the Claimant had not returned for follow up care. He obviously did not know that the Claimant was told by the doctor's staff which was that the Carrier had not authorized a follow

[6] While Claimant also relies on HIPPA in support of his argument for excluding Dr. Johnson's testimony, the only regulation he cites, 45 C.F.R. § 164.508, sets forth the general rule for obtaining a release of "individually identifiable health information" from a "covered entity" such as a health plan, health care clearinghouse, or health care provider. *See* 45 C.F.R. §§ 160.102, 160.103. The U.S. Department of Health and Human Services ("HHS") published its final *Standards for Privacy of Individually Identifiable Health Information* (the "Privacy Rule") on August 14, 2002. 45 C.F.R. Part 160 and Part 164, Subparts A and E. The Privacy Rule permits covered entitles to disclose protected health information to workers' compensation insurers, workers' compensation administrative agencies, or employers without the individual's authorization to the extent such disclosure is necessary to comply with laws relating to workers' compensation or similar programs including the LHWCA. *See* 45 C.F.R. §§ 164.522(a) and 164 .512 (a) and (l). Claimant has not explained why any disclosure during the conversation between Employer's counsel and Dr. Johnson prior to the deposition was not permitted under these regulations.

> up visit after the termination of benefits at the end of October. Dr. Dave responded in the letter that because the Claimant had not returned, he would give a full duty release to work but only on the condition that the lumbar MRI and cervical MRI and neurological evaluation and tests were completed. . . . It is not signed, it is stamped and the doctor traveled to India in December and died there in January, so there is no proof he even saw the final letter.

Dave Mot. at 3.

In response to Claimant's motion, Employer notes that the correspondence at issue is a typical business record, that counsel deposed the custodian of records from Dr. Dave's office who authenticated the letter as a business record, and the fact that Dr. Dave is no longer available to testify regarding the letter is irrelevant to its admissibility. Memorandum in Opposition to Motion for Exclusion of Letter of Dr. Dave to I.M.C. Representative at 1-2. I agree with Employer.

As a preliminary matter, I note that the correspondence referenced by Claimant is dated December 11, 2002, not, as he alleges in his motion, December 5, 2002. I further note that although Claimant asserts that Dr. Dave's letter was "not sent to Claimant's counsel," Dave Mot. at 3, the letter attached to Claimant's motion as Exhibit D, as well as the same letter found in Employer's exhibits as EX 10 at 10, expressly reflects that a copy was sent to "Anthony Cortese, 1111 N. Westshore Blvd., Tampa, FL," *i.e.*, Claimant's counsel. Furthermore, during the one hour deposition on October 8, 2003 of Brenda J. Kennedy Williams, the custodian of Dr. Dave's records, Ms. Williams confirmed that the December 11, 2002 letter was one of the records maintained in Claimant's medical file, and that the letter, as well as other documents in the file, had been "signed" with a stamp of Dr. Dave's signature. CX 18 at 9, 12-13.[7]

The LHWCA expressly provides that adjudicators conducting hearings under the Act "shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure . . . ." 33 U.S.C. 923(a). Although ex parte reports of a physician may be properly excluded from the record in some circumstances, *see, e.g., Avondale Shipyards v. Vinson*, 623 F.2d 1117, 1121 (5th Cir. 1980) and *Southern Stevedoring, Inc. v. Voris*, 190 F.2d 275, 277 (5th Cir. 1951), this is simply not such a case. First, this record is one of several records made and maintained in the ordinary course of business by *Claimant's* treating physician, not a physician who examined Claimant at Employer's request. There is absolutely no evidence to suggest that Dr. Dave's interests were adverse to Claimant at the time this report was generated. On the contrary, he simply responded to an inquiry by Carrier's representative based on the limited information he was provided. Indeed, he continued to recommend that Claimant (his patient) should only return to full-duty if the diagnostic testing he previously recommended were carried out. Second, the unavailability of Dr. Dave for cross-examination concerning the contents of the December 11, 2002 letter by Claimant's council was not procured or aided in any way by Employer. As Claimant has candidly acknowledged, Dr. Dave left this country for India shortly

[7] I also note that, although Claimant seeks to exclude Dr. Dave's letter from the evidentiary record, this very letter is among the exhibits offered by Claimant, and admitted by me, into evidence at the formal hearing in Orlando, Florida. CX 18, Exhibit C. Its inclusion appears to have been inadvertent in light of the fact that the letter is not included among the records of Dr. Dave identified by Claimant as CX 1.

after the letter was written and died while there. His death makes him equally unavailable to both parties in this litigation and hamper's Employer's ability to cross-examine Dr. Dave regarding opinions and statements favorable to Claimant as much as it does Claimant's ability to cross-examine him concerning statements which might not be as favorable. Third, even if the rules of evidence were strictly applied in these proceedings, which they are not, I find the letter has been properly authenticated and its contents are sufficiently reliable such that it would be admissible against Claimant either as an admission by a party opponent or under one or more of the many exceptions to the hearsay rule. *See, e.g.*, 20 C.F.R. §§ 18.801(d)(2)(i) and (iv), 18.803(a)(4) and (6). Claimant's motion to exclude the December 11, 2002 letter from Dr. Dave is therefore denied.

IV. STATEMENT OF THE CASE

Testimonial and Non-Medical Evidence

Claimant testified that he worked for Employer for more than 30 years performing various jobs including lead flagman, plant oiler, payloader operator, gantry operator, drywheel operator, and laborer. Tr. 64-65. He was working as a plant oiler on Friday, February 8, 2002, the day of the injuries which are the subject of this litigation. Tr. 67.

With respect to his injury, Claimant testified:

> I was walking -- I had just finished greasing the tail end of C-13 [conveyor], and there's a boardwalk down there, and when I finish that I usually walk down to check the trolley, the cable trolley, that the gantry rolls on, drags the cable behind it. I was going to check and grease that and the wheels of the gantry, and I stepped on a board and went through the dock. My foot come down hard on the pillar underneath.
> . . . .
> Yes, I was walking down there and stepped on the board, went through the dock. The board come up. . . .
> . . . .
> It came up, I went through it, my foot come to rest on that pillar underneath, and I was just trying to catch myself, flailing around trying to -- just trying to catch myself.

Tr. 70-71.

At the time of the accident, Claimant immediately felt pain in his ankle and, after extricating himself from the hole in the dock, reported to the shipping foreman that he "hurt [his] leg mostly." Tr. 72. Mr. Kortas, the foreman, told him to take it easy the rest of the day, and he finished out the shift. Tr. 73.

Claimant was having pain in his lower back by the end of the day, and reported that to Mr. Kortas as well. Tr. 73-74. Over the weekend, he was experiencing pain in his back and

neck, and he reported those problems to Mr. Kortas when he returned to work on Monday. Tr. 75.

Claimant was sent "to a nurse's station at Four Corners . . . [which is] an IMC mine in Polk County" for treatment. *Ibid*. He was treated with ice, bandages, a topical ointment "that smelled real bad," and medication for his leg, ankle, back, and neck. Tr. 76. He continued to work at his normal duties because he was "trying to impress them and be the next mechanic." Tr. 76-77.

Claimant saw the nurses at Four Corners several times thereafter, and he also went to Lakeside in Plant City where he saw a doctor. Tr. 77. He was sent for an MRI and subsequently told that he needed to see an orthopedist. Tr. 77-78. Dr. Johnson treated him on one occasion with cortisone injections in the back with no anesthesia. Tr. 78-79. His back felt "great" after the treatment, but it only lasted a little more than a week. Tr. 80-81.

Claimant was subsequently examined by Dr. Dave who sent him to Dr. Gari for pain management. Tr. 81. Dr. Gari also treated Claimant with injections to his back but used fluoroscopy and anesthesia. Tr. 84. He experienced "a little" relief after the injections but not as much as he had anticipated. Tr. 85.

After the February 8, 2002 accident, Claimant worked until April 3, 2002 when he had shoulder surgery for an unrelated injury. Tr. 82. He received workers' compensation benefits for the shoulder injury during the three months he was off. Tr. 83.

Claimant was examined by Dr. Finn at Carrier's request. Tr. 86. According to Claimant, Dr. Finn spent no more than about five or ten minutes with him. *Ibid*. He received a letter around the end of October telling him that his benefits were being terminated. Tr. 87. The letter enclosed a report from Dr. Finn that said there was nothing wrong with him. *Ibid*.

After receiving Dr. Finn's report and the letter from Carrier that his benefits were being terminated, Claimant talked to Richard Luke at IMC about coming back to work. Tr. 87-88. When he was not returned to work, he filed a grievance. Tr. 89. Employer's response to the grievance was to place Claimant on extended disability leave. Tr. 91, CX 12 at 16.

Claimant subsequently tried to go back to see Dr. Dave but was told he didn't have benefits anymore. Tr. 92. He later learned that Dr. Dave had passed away. *Ibid*.

Claimant was allowed to make an appointment to see Dr. Gari and was prescribed medication but was not given any further injections. *Ibid*. Dr. Gari recommended that he receive epidural and facet injections. *Ibid*. Dr. Gari ultimately released Claimant to light work with a five pound limitation and no lifting, twisting, bending stretching, standing or sitting over an hour without a break. Tr. 93. Claimant is unaware of any jobs he can perform within those restrictions and IMC has not offered him any jobs to which he could return. Tr. 93.

Claimant has constant back, leg, and neck pain, and the medication he is on (a duragesic patch) causes various problems including constipation, temperature swings, and skin irritation.

Tr. 93. He was previously on Vicodin and other medications which provided some pain relief. Tr. 94. A cane has been prescribed which he uses mostly for stability. Tr. 94-95. He also uses a muscle stimulator which provides some relief. Tr. 95.

Claimant was examined by Dr. Baker for approximately 25 to 35 minutes. Tr. 96. He recommended that Claimant continue to treat with Dr. Gari. Tr. 97.

Claimant recalled a few times after his February 8, 2002 injury when he could not physically perform some of his assigned duties. Tr. 101-03. His supervisors, however, were accommodating. Tr. 103-04. During the two-month period before his shoulder injury, Claimant did "step-up work" (jobs other than his regular duties as a "plant oiler" for which he received higher pay). Tr. 104-05. Claimant's back condition during that period was "comfortable" and did not get any worse. Tr. 107. He went out on April 3rd for his shoulder surgery and could not work at all while he recovered. Tr. 108. On June 4th when he was treated at Lakeside for his back, he told the doctor it "feels great today." Tr. 109. He was not released to return to work after his shoulder surgery until June 29th. Tr. 110. He did not go back to Lakeside for treatment for his back after June 4th because they wanted him to sign a release and pay a $10.00 co-pay. Tr. 110-11.

When Claimant returned to IMC on October 31st to see about his job, he first went to his attorney's office and called Mr. Eustice, the union representative, to arrange for him to meet Claimant at IMC. Tr. 112-13. He wanted Mr. Eustice to be there as a witness that he spoke with Richard Luke about returning to work because his benefits had been cut off. Tr. 114-15. He was using a cane when he met with Mr. Luke, and "was willing to do anything" but did not really feel like he was able to work. Tr. 116-18.

When asked to explain why his condition deteriorated between June and October 31, 2002 in light of the fact that he had no further injuries, Claimant testified:

> Well, first of all, when they stopped paying for any of the back, I think we were all -- you know, it was my opinion, I'm not a doctor, but no medication, nothing at all, only thing from him was pills, pills, pills, you know. That's all they were allowed to do. No treatment. Maybe I just deteriorated. I don't know what the problem is, I'm not a doctor. All I know is, I can tell you what hurts sometimes.

Tr. 119. He never contacted Employer or Carrier after his June 4th visit to Lakeside when they told him he would have to sign a release and pay a $10.00 co-pay for future visits. Tr. 120. His lower back and neck have continually gotten worse since June. Tr. 121. He did not return to IMC to ask them to put him back to work after Dr. Gari released him with restrictions. Tr. 122.

Timothy Eustice confirmed that he attended a meeting with Richard Luke and Claimant at IMC on October 31, 2002. Tr. 137. He did not recall seeing Mr. Kortas at that meeting. Tr. 138-39.

Alvin Kortas is a Maintenance Supervisor at IMC. Tr. 148. Claimant reported his injury to Mr. Kortas on February 8, 2002 and was treated by a nurse. Tr. 150. He was on modified

duty between then and when he left work due to his shoulder injury. Tr. 151. Claimant had surgery to repair a rotator cuff tear in his shoulder, which was unrelated to the February 8th accident, and has not been back to work at IMC since then. Tr. 153-54. Mr. Kortas was in the next room when Claimant and Timothy Eustice met with Richard Luke. Tr. 155. He observed Claimant using a cane and walking with difficulty but he had never seen him use a cane before that day. *Ibid*. He had seen Claimant several times between the day of the meeting and after he left work because of the shoulder surgery and did not remember him using a cane or having any difficulty walking. Tr. 156-57. He spoke with Claimant approximately two weeks before the meeting with Luke and Claimant told him was going to be coming back to work. Tr. 158-59.

The position of "Plant Oiler" requires, *inter alia*, inspecting plant equipment for proper lubrication, operating motorized equipment, and maintaining logs and checklists regarding work performed. CX 5. The position is classified as "medium work" and involves exerting up to 50 pounds of force occasionally, 20 pounds frequently, and 10 pounds constantly. *Ibid*.

An LS-202 "Employer's First Report of Injury or Occupational Illness" form dated February 22, 2002 notes that Claimant suffered a right ankle, lumbar, and cervical strain, resulting from an injury on February 8, 2002 when he stepped on a board that was nailed to a rotting beam and feel through a hole. EX 1 at 2. The form notes that Claimant did not stop work immediately, that medical attention was authorized, and he was treated by Christine Bouchard, RNP, at Lakeside Occupational Medical Centers. *Ibid*.

An LS-208 "Notice of Final Payment or Suspension of Compensation Payment" form reflects that Claimant first lost pay as a result of his February 8, 2002 injury on July 29, 2002. EX 2 at 1. Temporary total benefits were paid from that date until November 21, 2002 totaling $6,663.84 based on an average weekly wage of $603.20 and compensation rate of $402.13. *Id*. at 3.

An indemnity and medical payment summery from Carrier dated August 8, 2003 reflects payments totaling $6,663.84 for disability, $17,583.74 for medical, and $6,775.91 for expenses. CX 10.

Medical Evidence

Claimant was first seen at Lakeside Occupational Medical Centers by Dr. Riscile on March 22, 2002. EX 9 at 1, 8. He reported that his right ankle was improving but his lumbar strain continued to cause discomfort. *Ibid*. His cervical spine had normal range of motion but some pain on flexion, extension, and lateral movement. *Ibid*. X-ray findings regarding the right ankle, cervical spine, and lumbar spine were reported, and the assessment was "[r]esolving right ankle sprain, resolving cervical sprain, lumbar sprain rule out HNP." *Ibid*.

Claimant missed a follow-up visit with Dr. Johnson at Lakeside on March 28, 2002. EX 9 at 2. Notification of the missed visit was sent to Louise Dandridge, RN, at IMC. *Ibid*.

An MRI of the lumbar spine was performed on March 29, 2002. EX 9 at 7, EX 12. The MRI revealed diffuse lumbar spondylosis with dehydrated discs from L2 through L5, facet

hypertrophy from L3 through S1, and a diffuse annular disc bulge toward the left at L4/L5 with mild neuro foraminal narrowing on the left. *Ibid*.

Claimant was seen by Dr. Kasper at Lakeside on April 17, 2002. EX 9 at 3. He reported that his right ankle was well, and he was still having neck pain, headaches, and lumbosacral pain. *Ibid*. The assessment was lumbosacral strain and an orthopedic consult was ordered. *Ibid*. Work status at the time was noted as modified duty with a 20 pound weight restriction and no reaching above shoulder level. *Ibid*.

Claimant again missed a follow-up visit with Dr. Johnson at Lakeside on April 23, 2002. EX 9 at 3-4. Notification of the missed visit was again sent to Louise Dandridge, RN, at IMC. *Ibid*.

Claimant was again seen by Dr. Riscile at Lakeside on May 16, 2002. EX 9 at 4. He reported "a lot of back pain" and that physical therapy was not helping. *Ibid*. He had not worked since the end of March because of rotator cuff surgery. *Ibid*. The assessment noted was lumbar strain with MRI findings as previously described, and the plan was follow-up at Lakeside after the orthopedic evaluation had been completed. *Ibid*.

Claimant was seen by Dr. Johnson at Lakeside on May 30, 2002. EX 9 at 5. Physical examination revealed normal straight leg raising, symmetric active reflexes at the knees and ankles with good strength, and tenderness over L3, L4, and L5. *Ibid*. A total of six IMC-approved deep nerve injections were done at L3/4, L4/5, and L5/S1 on the right and left. *Ibid*. A restriction of no lifting over 40 pounds was noted. *Ibid*. Dr. Johnson also wrote:

> Discuss [sic] was had with the patient concerning his underlying degenerative disease in his back which is normal for age, and I stressed that we can treat this acute strain/sprain and it will resolve but he will still have his underlying degenerative changes.

Ibid.

On June 4, 2002, Claimant was seen by Antoinette Welch, a Nurse Practitioner at Lakeside and reported that his back was "much, much better" and he felt "great today." EX 9 at 5. He was released to regular duty status as of that date. *Id*. at 6.

Claimant was seen by Dr. Naresh Dave on July 5, 2002. CX 1, EX 10. Presenting symptoms included headaches, neck pain, low back pain, right leg pain, pain in both hip joints, and numbness of the left little toe. *Id*. at 1. Claimant's description of the injury on February 8, 2002 was:

> The patient said he was on a shipping dock. He was going towards a trolley that needed greasing. A board on the shipping dock went down on one side and came up on the other side and he went down all the way. The right leg went up to the knee. It severely jolted him and threw him sideways.

> Following the same, the patient extricated himself out of the situation. He first felt that he had an ankle sprain then he started noticing the back pain within about 20 minutes after that. Twenty-four (24) hours later, he started having headache and neck pain.

Ibid. Claimant's gait and heel-toe walking were normal, but he experienced pain in the lower back on squatting to 50 percent. *Id*. at 2. Examination of the lower extremities was essentially normal with the exception of numbness in the right fifth toe. *Id*. at 3. He had 1+ paralumbar muscle spasm and range of motion was somewhat restricted with pain on flexion. *Ibid*. Thoracic and cervical spine were essentially normal. An MRI of the lumbar spine showed a bulging disc at the L4/5 level with no herniation, disc dehydration, or disc space narrowing. *Id*. at 4. The diagnoses were low back strain, sprain of the left hip joint, bulging disc at L4-5, posttraumatic headaches, and cervical strain by history. *Id*. at 5. Dr. Dave recommended further treatment including epidural injections through pain management specialist for the lumbar spine. *Ibid*. Claimant had not then reached maximum medical improvement ("MMI") and he was considered temporarily totally disabled. *Id*. at 6-7.

Claimant was seen by Dr. Rodolfo Gari at the Tampa Pain Relief Center beginning August 2002. CX 2. A treatment note dated August 27, 2002 reflects a chief complaint of low back pain that radiates into both legs. *Id*. at 23. Review of a March 29, 2002 MRI at that time revealed spondylosis of the lumbar spine with dehydrated discs from L2 to L5 and facet hypertrophy from L3 to S1, diffuse annular disc bulge with paracentral component toward the left at L4 to L5, and neural foraminal narrowing on the left. *Id*. at 25. Dr. Gari recommended a plan of caudal epidural steroidal injections under fluoroscopy, facet injections, and medication. *Ibid*.

As noted above, Claimant was examined by Dr. Charles A. Finn at Advanced Orthopaedic Associates in St. Petersburg, Florida on August 28, 2002. EX 8. According to the history noted in Dr. Finn's report, Claimant sustained an on-the-job injury on February 8, 2002 to his neck, back, right ankle, and right knee when he fell through a dock down to his knee when a plank gave way. *Id*. at 1. He reporting going to a walk-in clinic the following day, and that he has seen or been treated by Dr. Bouchard, Dr. Johnson, Dr. Riscile, and Dr. Dave. *Id*. at 2. Treatment included physical therapy, medications, and injections, and he stated that activities such as sitting, standing, walking, and bending aggravated his condition. *Ibid*. The findings on physical exam and diagnoses are as noted *supra*. The conclusion portion of the report states:

> In summary, this is a gentleman who now after an injury on February 8, 2002 complains of non-specific, non-dermatomal, and non-radicular neck pain and back pain after this fall through the dock. An end result has been achieved. Further treatment is not medically necessary, reasonable, or related regarding this accident. Further diagnostic testing in [sic] not medically necessary, reasonable, or related regarding this accident.
>
> There is a prior injury that had resolved 20 years ago. There is no functional impairment, based on today's examination. The examinee is not disabled. He has a normal orthopedic and neurologic examination. I do reserve the right to

> reconsider my opinion, if given the opportunity to review the diagnostic testing, including the two MRI's of the cervical and lumbar spine.
>
> He is capable of full time full duty work. He needs no assistance with activities of daily living. There is no need for a structured physical therapy program or further treatment. He has had an excessive amount of physical therapy at HealthSouth. He has reached maximum medical improvement with a zero percent impairment rating. Except for the excessive length of physical therapy, the other treatments and diagnostics were medically necessary and related to the accident.

Id. at 3-4.

A caudal epidural steroidal injection under fluoroscopy was performed by Dr. Gari on September 16, 2002. CX 2 at 31. During a September 24, 2002 visit, Claimant reported continuous moderate pain made better with medication and worse by prolonged standing or sitting. *Id*. at 32. Limited range of motion and spinal tenderness to digital palpation of the lumbar region were noted, and a second caudal epidural steroidal injection under fluoroscopy was recommended along with Vicodin. *Id*. at 33.

On October 2, 2002, Kelley M. Mandella, RN, Medical Case Manager for Constitution State Service Company in New Orleans, Louisiana wrote to Dr. Dave, provided him with a copy of Dr. Finn's IME report, and asked whether he agreed with the results reported therein. EX 10 at 11. A similar letter was sent to Dr. Gari. EX 11 at 6.

A caudal epidural steroidal injection under fluoroscopy was carried out by Dr. Gari on October 14, 2002. CX 2 at 35. No improvement was reported by Claimant a week after the injection. *Id*. at 36. He described the pain at that time as severe and his condition as worsening. *Ibid*. Pain in both the cervical and lumbar regions, as well as intermittent headaches, was reported. *Ibid*. Dr. Gari recommended a plan of right lumbar facet joint injections, medication, and no work until Claimant could be reevaluated after the next follow-up visit. *Id*. at 38.

Claimant was seen by Dr. Dave on October 28, 2002 for symptoms involving headache, neck pain, low back pain radiating down the left leg associated with numbness in the L4 nerve root distribution, discomfort in the left leg, and weakening in the low back especially with standing for long periods. CX 1 at 8. Gait, heel-toe walking, and squatting were all normal. *Ibid*. Sensory examination indicated paraesthesias in the distribution of the L4 nerve root down the left lower extremity. *Ibid*. Claimant again had 1+ paralumbar muscle spasm and rigidity to 1 degree in the lumbar spine. *Id*. at 9. He also had 1+ paracervical muscle spasm, diminished range of motion, and moderate rigidity of the muscles in the cervical spine. *Ibid*. A re-review of the MRI done in February was interpreted by Dr. Dave as showing left paracentral disc herniation at L4/5 with neuroforaminal narrowing on the left side. *Ibid*. Dr. Dave wrote "[i]t is my opinion that this could be a frank disc herniation causing the sensory changes that the patient is complaining of." *Ibid*. He therefore recommended a repeat MRI of the lumbar spine with contrast, an MRI of the cervical spine, and consultation with a neurologist. *Ibid*.

Claimant continued to report moderate to severe pain in the lumbar and cervical regions and constant headaches when seen again by Dr. Gari on November 25, 2002. CX 2 at 39. Claimant reported using a cane. *Id*. at 40. Range of motion was limited, muscle strength and tone were normal, and there was tenderness to the lumbar and mid spine and bilateral facet joints. *Ibid*. Dr. Gari's plan was to "[r]eschedule left lumbar facet joint injections – re-attempt insurance authorization." *Id*. at 41.

In a December 11, 2002 letter to Kelly Mandella, Dr. Dave wrote that he had not seen Claimant since October 28, 2002. EX 10 at 10. He noted that "the investigation that I had recommended regarding this patient's condition has not been carried out." He stated that Claimant could be returned to full-duty if the previously recommended MRIs of the lumbar and cervical spine and a neurological consultation were carried out. *Ibid*. He further noted, however, that Claimant's work status was dependant on the results of the studies. *Ibid*.

When seen December 20, 2002 through August 1, 2003 by Dr. Gari, Claimant reported problems similar to those previously recorded. CX 2 at 44-72. Ambulation with the assistance of a cane was first noted beginning January 21, 2003. *Id*. at 46. With the exception of April 10, 2003 and May 12, 2003 visits, *id*. at 58, 61, all records from other office visits during this period reflected ambulation with the assistance of a cane.

Kelley Mandella wrote to Dr. Finn on January 29, 2003, noted that a report of a March 29, 2002 MRI of Claimant's lumbar spine had not been reviewed at the time of Dr. Finn's August 28, 2002 IME, and asked that the report be reviewed. EX 8 at 10. She also noted that Dr. Gari had ordered a repeat lumbar MRI and a cervical MRI and asked for Dr. Finn's opinion regarding whether they were necessary. *Ibid*.

In a letter dated January 31, 2003 to Kelley Mandella, Dr. Finn stated that he had reviewed a March 29, 2002 MRI report which reflected "some mild foraminal stenosis and no clinical evidence of any sympathology [sic]." EX 8 at 6. Dr. Finn further stated that the opinion in his August 28, 2002 IME report had not changed and neither another lumbar MRI nor a cervical MRI were necessary. *Ibid*.

Ms. Mandella again wrote to Dr. Finn on April 24, 2003 and asked for his opinion regarding whether certain medication was appropriate with respect to Claimant's work-related injury. EX 8 at 11.

An April 28, 2003 letter to Ms. Mandella from Dr. Finn reflected his opinion "that Duragesic patch, Miralax, Vicodin and Bextra are not needed in regard to this work injury since the time I examined this patient on January 31, 2003. EX 8 at 7.

Claimant was examined by Dr. John C. Baker, an orthopedic surgeon, on August 18, 2003. CX 3. He was evaluated for neck pain, back pain, and right ankle pain. *Id*. at 74. He reported that he was not then working "for medical reasons" and that he did not participate in sports or athletics. *Id*. at 74-75. His pain had gotten progressively worse since his February 8, 2002 accident and was aggravated by walking, standing, sitting, and activity in general. *Id*. at 75. He reported that he was able to walk only one or two blocks. *Ibid*. Dr. Baker noted on

physical examination that Claimant listed forward and to the right at all times. *Ibid*. He had, *inter alia*, 3+ paraspinal muscle spasm in the lumbar area, difficulty heel-toe walking, flattening of the lumbar lordosis, tight hamstring muscles bilaterally, and normal motor, sensory, and reflexes of the lower extremities. *Id*. at 75-76. X-rays of the cervical and lumbar spine showed multiple level degenerative disc and facet disease. *Id*. at 76. An MRI of the lumbar spine showed diffuse lumbar degenerative disc and facet disease from L2 through L5, and a bulged disc at L4-5 with mild neuroforaminal narrowing on the left. Dr. Baker's impression was multiple level cervical and lumbar degenerative disc disease with the February 8, 2002 injury identified as an aggravating factor and contributing cause of Claimant's then-current complaints. *Ibid*. Dr. Baker stated that claimant had not reached MMI, continued to be temporarily totally disabled, needed to continue with Dr. Gari for pain management, and needed an MRI of the cervical spine. *Ibid*. He did not recommend surgery or further testing of the lumbar spine. *Ibid*.

Dr. Finn was deposed by Claimant's counsel on October 6, 2003 as described *supra*. EX 14. He had no independent recollection of seeing any of the medical records provided to him prior to his August 28, 2002 IME, including the July 5, 2002 report of Dr. Dave. *Id*. at 12. Dr. Finn did recall that he reviewed the report of the March 29, 2002 lumbar spine MRI, and he stated that it showed degenerative changes. *Id*. at 14. When asked if an arthritic condition could be made symptomatic by trauma, he testified:

> There would have had to [have] been an injury, like an injury to a disk, an injury to a ligament, a broken facet joint. The MRI didn't show any of that. It just showed some wear and tear arthritis that you would expect in any 50-year-old gentleman. You're going to see those findings. If there was a broken facet joint that caused arthritic condition, if there was a herniated disk that caused the disk to deteriorate and degenerate, if there was a tear of the interspinous ligament, if there was a tear of any of the longitude ligaments, if there was any subluxation, if there was anything like that, then the arthritic condition could cause a permanent aggravation of – the traumatic injury could cause a permanent aggravation. But there wasn't any of this. The MRI only just showed some degenerative – some foraminal stenosis. There wasn't any of that on the report that I reviewed. And I'll be happy to take a look at the film and see if there's anything there. But according to that report, if the radiologist interpreted that appropriately, it wouldn't change my opinion a bit.

Id. at 14-15. Dr. Finn made it clear that he reviewed only the report of Claimant's March 29, 2002 MRI and not the MRI film itself. *Id*. at 14. He did not believe that a repeat MRI with contrast was necessary or appropriate since there had been no prior surgery or indication of an infection, osteomyelitis, or a bone tumor. *Id*. at 16. He similarly rejected the need for a neurological evaluation since there were no symptoms of radiculopathy when he examined Claimant on August 28, 2002. *Id*. at 17. It was Dr. Finn's opinion, based on his physical findings and the MRI report, that the IME he performed on August 28, 2002 was completely normal, Claimant could return to work with no restrictions, and there was no need for further medical care. *Id*. at 21-22. Dr. Finn testified that he estimated he spent approximately "15 minutes, if that" examining Claimant at the time he performed his IME. *Id*. at 36. The total

time spent in preparing the report of the IME would depend on the amount of medical records he had to review. *Ibid*.

Dr. Johnson was deposed by Employer's counsel on October 15, 2003. EX 16. He is in private practice in the State of Florida and has six offices in the Tampa Bay area which provide occupational medicine services for a number of employers in that area. *Id*. at 7. IMC is one of the employers with which Lakeside Medical Center has a contract to provide staffing services and medical professionals for implementation of company-based occupational health programs. *Id*. at 11, 13. It also provides, *inter alia*, consulting services for disability management and worker's compensation matters. *Ibid*. Dr. Johnson is the Medical Director of Lakeside. When he saw Claimant on May 30, 2002, he had subjective reports of pain in the lower back. *Id*. at 32. Weight restrictions were increased from 20 to 40 pounds at that time since there was no specific pathology noted during the prior two months of treatment. *Id*. at 33. Injections performed on that date resulted in improvement. *Id*. at 34.

Dr. Baker was deposed by Claimant's counsel on October 17, 2003. CX 16. It was his opinion, based on the August 2003 examination, and a review of x-ray and MRI evidence obtained by him and others, that Claimant had multiple level cervical and lumbar degenerative disk disease which was aggravated by his February 8, 2002 work injury. *Id*. at 546-47. He further opined that the major contributing cause of Claimant's then-current complaints were the same work injury, and that Claimant was temporarily and totally disabled. *Id*. at 547-48. It was Dr. Baker's opinion that deep nerve root injections performed without fluoroscopy, like those administered by Dr. Johnson, could worsen an individual's spine condition, and that such a procedure with fluoroscopy was much safer and more accurate. Tr. 550. He agreed that the procedure could be conducted properly without fluoroscopy. Tr. 551. If done incorrectly without fluoroscopy, it could cause inflammation and bleeding around a nerve that was previously normal or possibly cause an allergic reaction. *Id*. at 553, 558. Dr. Baker's recommendation for a cervical MRI was based on Claimant's complaints. *Id*. at 566. He has not seen Claimant again since the August 18th examination. *Id*. at 563. Claimant was not using a cane to assist him in ambulating at the time of the examination. *Id*. at 570. However, he ambulated bent forward and listing to the right at all times during the examination and had difficulty heel-toe walking. *Ibid*.

Dr. Gari was deposed by Claimant's counsel on October 14, 2003. CX 17. Dr. Gari first saw Claimant on August 27, 2002 on referral from Dr. Dave for treatment of low back pain. *Id*. at 594. Treatment recommended was epidural steroid injections. *Ibid*. Facet injections were recommended also but never authorized. *Id*. at 597-98. Prescribed medications included a muscle relaxer, sleeping pills, and pain medication. *Id*. at 598. Dr. Gari recommended in January 2003 that Claimant consult a neurosurgeon and neurologist. *Ibid*. He also recommended an MRI of the lumbar spine. *Id*. at 599. It was his opinion that these would assist in determining what further treatment was reasonable and necessary. *Ibid*. In March 2003, Dr. Gari's medical partner saw Claimant and recommended a lumbar discogram to determine if Claimant's disc was compromised and causing pain. *Id*. at 600. A muscle stimulator was also recommended to help with muscle spasms and to strengthen the back muscles. *Id*. at 600-01. Claimant was seen on July 7, 2003 by Rebecca Andress, a nurse practitioner in Dr. Gari's office, and diagnosed with, *inter alia*, cervicalgia and radiculopathy to the upper extremities. *Id*. at

601-02. Cervicalgia is a medical term for neck pain. *Id*. at 602. Dr. Gari concurred in the recommendation by Dr. Dave in an October 28, 2002 report that Claimant have an MRI of the cervical spine. *Ibid*. Claimant would not be considered to have reached MMI if he could receive further recommended treatment. *Id*. at 606. Claimant would be unable to perform the job of Plant Oiler which required lifting up to 50 pounds occasionally, 20 pounds frequently, and ten pounds constantly. *Id*. at 607. There was no significant change in Dr. Gari's objective findings regarding Claimant throughout the course of his treatment. *Id*. at 608. Claimant's work status was changed on March 4, 2003 from unable to work to able to work with no lifting over five pounds and no repetitive bending, stretching, or twisting, no prolonged standing, and no sitting longer than one hour with a five-minute break to stretch. *Id*. at 612. Dr. Gari's decision to send Claimant back to work on light duty was based on the fact that the facet injections he had been recommended were not going to be authorized. *Id*. at 613.

Dr. Dave's records relating to treatment of Claimant were produced by Brenda Joyce Kennedy Williams, his records custodian, at a deposition on October 8, 2003. CX 18. Claimant's entire medical file, with the exception of records from other physicians, was produced. *Id*. at 7-8. In addition to the reports of examination dated July 5, 2002 and October 28, 2002 described above, Ms. Williams produced an October 2, 2002 letter from Kelley M. Mandella, RN, Traveler's Medical Case Manager, to Dr. Dave. *Id*. at 743. The letter states, in relevant part:

> We obtained an independent Medical Evaluation with Dr. Finn regarding Mr. King's Worker's Compensation back injury. A copy has been provided for you to review. Do you agree as Dr. Finn has stated that further treatment is not medically necessary, reasonable or related regarding [the February 8, 2002] accident? Do you also agree that he is capable of full duty work?

Ibid. Ms. Williams also produced a letter dated December 11, 2002 from Dr. Dave responding to Ms. Mandella's letter in which he states:

> The last time I saw Mr. Gary King was on October 28, 2002. Since then, I have not seen this patient. At that time, the patient was not working. I understand that at that time, the investigation that I had recommended regarding this patient's condition has not been carried out. Therefore, I would request two things that you could return him to full-duty work pending you agree to carry out the above investigations which I had recommended namely, MRI of the lumbar spine with contrast, MRI of the cervical spine and neurological consultation.
>
> If they are found to be adverse to the patient's condition then his work status may change. At this time, since the patient has not come back to see us from October 28, 2002, I am releasing him back to full-duty work.

Id. at 744. A "Work Status" form also produced by Ms. Williams notes "Temporary Total Disability until next visit" and is dated and signed by Dr. Dave on July 26, 2002. *Id*. at 745.

V. DISCUSSION

A. Causation of Cervical Spine Injury.

The LHWCA provides that, absent substantial evidence to the contrary, a claim for benefits comes under the provisions of the Act. 33 U.S.C. § 920(a). The claimant must establish a *prima facie* case by proving that he or she suffered some harm or pain, *Murphy v. SCA/Shayne Brothers*, 7 BRBS 309 (1977), *aff'd mem.*, 600 F.2d 280 (D.C. Cir. 1979), and that an accident occurred or working conditions existed which could have caused the harm. *Kelaita v. Triple A Mach. Shop*, 13 BRBS 326 (1981). *See U.S. Indus./Fed. Sheet Metal v. Director., OWCP (Riley)*, 455 U.S. 608, 14 BRBS 631, 633 (1982), *rev'g Riley v. U.S. Indus./Fed. Sheet Metal*, 627 F.2d 455, 12 BRBS 237 (D.C. Cir. 1980); *Gooden v. Director, OWCP*, 135 F.3d 1066, 32 BRBS 59 (CRT) (5th Cir. 1998); *Bolden v. G.A.T.X. Terminals Corp.*, 30 BRBS 71 (1996); *Stevens v. Tacoma Boatbuilding Co.*, 23 BRBS 191 (1993). The claimant is not required to introduce affirmative medical evidence that the working conditions in fact caused the alleged harm; rather, the claimant must show that working conditions existed which could have caused the harm. *See generally U.S. Indus./Fed. Sheet Metal, Inc.*, 455 U.S. 608, 14 BRBS at 631. A claimant's credible subjective complaints of pain alone may be sufficient to establish the injury element of the *prima facie* case even though there is no objective findings that claimant is harmed. *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 339 (1988).

I find that Claimant has established that he sustained physical harm or pain to his cervical spine while working for Respondent as a result of working conditions which conceivably could have caused that harm or pain. Claimant testified that he was walking on a boardwalk at IMC's facility on February 8, 2002 when a piece of rotten timber gave way and he fell through the boardwalk striking a block of concrete underneath. He testified:

> I was walking down there and stepped on the board, went through the dock. The board come up. . . .
> . . . .
> It came up, I went through it, my foot come to rest on that pillar underneath, and I was just trying to catch myself, flailing around trying to -- just trying to catch myself.

Tr. 70-71. He immediately felt pain in his ankle and, by the end of the day, felt pain in his low back as well. Tr. 72-74. Over the weekend, he began feeling pain in his neck also, and he reported those problems to his supervisor when he returned to work on Monday. Tr. 75. Claimant was treated at the nurse's station at Four Corners for his leg, ankle, back, and neck. Tr. 76. He had ongoing complaints of back, leg, and neck pain since the time of the accident. Tr. 93, 121. His testimony with respect to the accident giving rise to his injuries is consistent with documentation describing the incident, and his description of the resulting injuries and ongoing complaints of cervical pain is corroborated by statements made to various medical practitioners since the date of the accident. *See, e.g.*, EX 9 at 1, 3, 8; EX 10 at 1; CX 1 at 8; CX 2 at 36, 39; CX 3 at 74, 76. I find that testimony credible. Claimant has thus established a *prima facia* claim for compensation.

If a claimant establishes a *prima facie* case, the presumption is created under Section 20(a) that the employee's injury arose out of employment. To rebut the presumption, Employer must present substantial evidence proving the absence of or severing the connection between such harm and employment. *Parsons Corp. of California v. Dir., OWCP*, 619 F.2d 38 (9th Cir. 1980); *Butler v. District Parking Mgmt. Co.*, 363 F.2d 682 (D.C. Cir. 1966); *Ranks v. Bath Iron Works Corp.*, 22 BRBS 301, 305 (1989). Substantial evidence is the kind of evidence a reasonable mind might accept as adequate to support a conclusion. *See, e.g., Travelers Ins. Co. v. Belair*, 412 F.2d 297 (1st Cir. 1969).

Claimant was examined by Dr. Finn on August 28, 2002 who performed an IME that date on behalf of Employer. EX 8. Dr. Finn concluded that:

> An end result has been achieved. Further treatment is not medically necessary, reasonable, or related regarding this accident. Further diagnostic testing in [sic] not medically necessary, reasonable, or related regarding this accident.
> . . . . .
> He is capable of full time full duty work. He needs no assistance with activities of daily living. There is no need for a structured physical therapy program or further treatment. He has had an excessive amount of physical therapy at HealthSouth. He has reached maximum medical improvement with a zero percent impairment rating. Except for the excessive length of physical therapy, the other treatments and diagnostics were medically necessary and related to the accident.

Id. at 3-4. The report does not address causation with respect to Claimant's cervical complaints. Similarly, when deposed on October 6, 2003, Dr. Finn expressed no opinion with respect to whether Claimant's reports of cervical pain since the time of the February 8, 2002 accident were a result of the accident. EX 14.

Employer's post-hearing brief is silent with respect to the issue of whether Claimant sustained a neck injury at the time of the accident which gave rise to this litigation.[8] Claimant's post-hearing brief notes, in relevant part:

> The relevant facts are that there was an unexpected fall through a wooden walkway, followed by twisting and flailing by Gary King to try to get his balance, followed by a jolt when his right foot struck a concrete pillar about two feet under the walkway. The jolt immediately injured the right leg and ankle. In the first report of injury, Gary King reported injury to the right ankle and low back. Within the first week, he was seen at Lakeside, the employer's on site medical clinic, and during February they were treating the right ankle and low back and neck according to work releases.
>
> In the first formal report of injury by the employer to the Department of labor, the right ankle and low back and neck are listed as part of the injury (C 140). From the first visits to Lakeside to the present there have been complaints

[8] Employer does contest Claimant's entitlement to treatment for his neck, including undergoing a cervical MRI. Emp. Br. at 18. That issue is discussed further *infra*.

> of the low back and neck injuries that have been treated. The bills for the care have been paid and Dr. Dave was initially authorized to evaluate and treat the neck and low back as reflected in his reports. . . .

Cl. Br. at 16.

I find that Employer has failed to present substantial evidence proving the absence of, or severing the connection between, Claimant's alleged harm to his neck and his employment. Although Dr. Finn, Employer's physician, has opined that there is no need for further treatment or testing with respect to Claimant's neck condition, he does not assert that the cervical pain experienced by Claimant after the February 8, 2002 accident was unrelated to the accident. I therefore find that Employer has failed to rebut the presumption under Section 20(a) that this injury arose out of employment.

B. Nature and Extent of Disability.

At the heart of this controversy is the nature and extent of any ongoing disability resulting from Claimant's February 8, 2002 accident.[9] As noted above, Claimant continued to work after his accident until April 3, 2002 when he had shoulder surgery for an unrelated injury. Tr. 82. Employer voluntarily paid temporary total disability benefits with respect to the injuries associated with the February 2002 accident beginning July 29, 2002, but it terminated those payments effective November 21, 2002. EX 2. Employer now asserts that "[a] fair and accurate review of the facts in this matter . . . can only lead to the conclusion that the employer overpaid temporary total disability benefits and should be entitled to credit." Emp. Br. at 14. It further states:

> Because there are no objective findings of injury, even with the claimant's own treating physicians, it only stands to reason that they are basing their statements of disability on the subjective complaints of the claimant. Given that the claimant's credibility and motives have come under severe scrutiny at the trial of this matter, the physicians' opinions regarding disability based upon the subjective complaints should be viewed unfavorably as well.

Id. at 15. Employer relies principally on the opinions of Drs. Finn and Johnson to support its contention that Claimant was not disabled by his injuries.

An administrative law judge is not bound to accept the opinion or theory of any particular medical examiner. *Lombardi v. Universal Maritime Service*, 32 BRBS 83 (1998); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). Indeed, there is no requirement in the Act that medical testimony be introduced to support a claim. *Ballard v. Newport News Shipbuilding & Dry Dock Co.*, 8 BRBS 676 (1978); *Ruiz v. Universal Maritime Service Corp.*, 8 BRBS 451 (1978). A finding of disability may be based on a claimant's credible complaints of pain alone. *Anderson v. Todd Shipyards*, 22 BRBS 20 (1989); *Miranda v. Excavation Construction, Inc.*, 13 BRBS 882, 884 (1981); *Eller and Co. v. Golden*, 12 BRBS 348, 620 F.2d

[9] Employer has already stipulated that Claimant sustained a back and right ankle injury. ALJX 2. As noted above, I have also found that he sustained a neck injury as well.

71 (5th Cir.), *aff'g* 8 BRBS 846 (1978). Even a minor physical impairment can establish total disability if it prevents the employee from performing his usual employment. *Elliot v. C & P Tel. Co.*, 16 BRBS 89, 92 (1984); *Equitable Equip. Co. v. Hardy*, 558 F.2d 1192 (5th Cir. 1977). A review of all the evidence in this case, and the applicable case authority, supports a finding of temporary total disability.

Claimant initially received treatment for injuries sustained after his February 8, 2002 accident at Lakeside Occupational Medical Centers. EX 9. The only time Claimant was seen by Dr. Johnson was on May 30, 2002 when he administered a total of 6 deep-nerve injections at L3/4, L4/5, and L5/S1 on the right and left sides. *Id*. at 5. Dr. Johnson noted a work restriction at that time of no lifting over 40 pounds, which was an increase from the 20 pound limitations previously imposed by other Lakeside physicians. *Ibid*., EX 16 at 33. The increase was based on the lack of "specific pathology" noted during the prior two months of treatment and the spinal injections given by Dr. Johnson at that time. EX 16 at 33. On June 4, 2002, the last time Claimant was seen at Lakeside, Antoinette Welch, a nurse practitioner, released Claimant to "regular duty" based on Claimant's statements that his back felt "great" at that time. EX 9 at 5-6.

The medical evidence from Lakeside is clearly the most remote in time of all the medical evidence of record. Indeed, it covers a period *before* July 29, 2002 when Claimant first lost any wages as a result of his accident and Employer began paying temporary total disability benefits. *See* EX 2. Dr. Johnson's deposition testimony with respect to his one-time treatment of Claimant and his review of these records adds little if anything to the information contained therein. I thus find this evidence has limited probative value when considered in the context of the other medical evidence of record.

Employer's expert, Dr. Charles Finn, performed an IME of Claimant on August 28, 2002 which, according to Dr. Finn himself, lasted "15 minutes, if that." EX 8, EX 14 at 36. He reviewed some medical records of Claimant's treatment but had no independent recollection of seeing any of those records other than a March 29, 2002 lumbar spine MRI report. EX 14 at 12, 14. He determined that the examination was essentially normal and opined that: Claimant was capable of "full time full duty work;" there was no need for further medical care; and Claimant had reached MMI. EX 8 at 3-4, EX 14 at 21-22. Dr. Finn's opinion is directly contradicted by other evidence of record from examining and treating physicians, as well as Claimant's testimony, which I find more credible and persuasive.

According to Claimant, he has constant back, leg, and neck pain, and the medication he takes causes various problems including constipation, temperature swings, and skin irritation. Tr. 93. Prescribed medication has provided some pain relief, as does the muscle stimulator he uses, but he now has to use a cane, mostly for stability. Tr. 94-95. On October 31, 2002, Claimant spoke to his supervisor at IMC, Richard Luke, about returning to work because his benefits had been cut off, but he did not really feel like he was able to work at that time. Tr. 112-13, 116-18. His back and neck have continually gotten worse since June when he stopped going to Lakeside. Tr. 121.

After having observed the Claimant's demeanor at trial, listening to his testimony, and reviewing the entire record in this matter, I find Claimant's testimony credible and entitled to substantial weight.[10] His complaints of ongoing lumbar and cervical spine pain are consistent with, and verified by, various notations reflected in the treatment records from the time of his February 8, 2002 accident to the present. Furthermore, as more particularly described below, his assertion that he can no longer perform his prior duties at IMC as a "plant oiler" are supported by the opinions of his treating and examining physicians.

The recommendation that Claimant undergo an orthopedic examination, was first made by Dr. Kasper at Lakeside on April 17, 2002. EX 9 at 3. Dr. Naresh Dave, an orthopedic specialist, examined Claimant both before and after he was examined on August 28, 2002 by Dr. Charles Finn, Employer's expert. CX 1.

When he first examined Claimant on July 5, 2002, Dr. Dave's physical findings included a notation that Claimant could squat to only 50 percent of normal with pain in the lower back, and that he had lumbar spine pain on flexion and extension with rigidity of 1- degree, and 1+ paralumbar muscle spasm. He diagnosed Claimant as having, *inter alia*, low back strain, bulging disc at L4/5, posttraumatic headaches, and cervical strain by history. *Id*. at 3-5. In Dr. Dave's opinion, Claimant had sustained a permanent injury but had not yet reached MMI, and he recommended that a decision on whether Claimant could return to work be made only after he received the epidural injections he recommended. *Id*. at 6.

Dr. Dave again examined Claimant on October 28, 2002. *Id*. at 8-10. He noted 1+ paralumbar and paracervical muscle spasm with moderate rigidity of the muscles in both areas. *Id*. at 9. He re-read the lumbar MRI he had reviewed at the time of the first examination and stated that it showed a left paracentral disc herniation at L4/5 with mild neuroforaminal narrowing on the left side which he believed "could be a frank disc herniation causing the sensory changes that the patient is complaining of." *Ibid*. He therefore recommended a repeat MRI of the lumbar spine with contrast, an MRI of the cervical spine, and a consultation with a neurologist. *Ibid*. Under the heading "Work Status" he listed "No work." *Id*. at 10.

In a letter dated December 11, 2002, shortly before his death, Dr. Dave informed Employer that he had not seen Claimant since the October 28, 2002 examination, and that any return to full-duty work status was conditioned on the results of the lumbar MRI with contrast, cervical MRI, and neurological consultation previously recommended by Dr. Dave at the time of his last examination. CX 18 at 744.

I find Dr. Dave's opinions well reasoned, based on the results of both objective medical tests and the credible subjective complaints of Claimant, and consistent with the medical treatment records of Dr. Rodolfo Gari. On physical examination, Dr. Dave noted muscle spasm, restricted range of motion, and pain on flexion and extension. He also described sensory changes which he attributed to an L4/5 disc herniation shown on MRI. He recommended that

[10] I specifically note that Claimant appeared to be in some physical distress throughout the hearing and his movements at that time were slow and somewhat guarded. Indeed, at one point during his testimony he was allowed to stand to alleviate pain in his back. Tr. 112.

Claimant undergo pain management treatment with Dr. Gari, as well as various other diagnostic testing and consultation with a neurologist.

Between July 29, 2002 and November 21, 2002, the period during which Employer voluntarily paid temporary total disability compensation for Claimant's February 8, 2002 injuries, medical records reflect that Claimant was treated by Dr. Gari for neck and low back pain that radiated into both legs. Tr. 81, CX 2. With respect to work status, treatment notes dated August 27, September 24, October 21, November 25, and December 20, 2002 reflect "[o]ff work until next follow up appointment and then reevaluate." *Id*. at 29, 33, 38, 41, 44. The note from October 21, 2002 also reflects "cane for chronic pain." *Id*. at 38. A treatment note from November 25, 2002 orders that left lumbar facet joint injections be rescheduled and states "re-attempt insurance authorization." *Id*. at 41. Dr. Gari's treatment notes are thus clearly consistent with the temporary total disability compensation payments made by IMC to Claimant.

Dr. Gari's records after November also continue to support an award of temporary total disability benefits. A handwritten note dated December 2, 2002 reflects "[Claimant] incapable of work at this time." *Id*. at 22. A December 20, 2002 treatment note orders that a right lumbar facet joint injection be rescheduled "pending insurance authorization." *Id*. at 44. A treatment note dated January 21, 2003 reflects "[p]rocedure still pending due to authorization. Patient states pain increase in his neck and legs. Orthopedic surgeon passed away – need new one." *Id*. at 45. Work status continued to be reported then, as well as on February 18, 2003, as "[o]ff work until next follow up appointment and then reevaluate." *Id*. at 47, 50. On March 4, 2003, work status was changed to "Do not lift over 5 pounds. No repetitive bending, stretching or twisting. No prolonged standing, sitting longer than one hour with a five minute break to stretch." *Id*. at 53. The same limitations were noted on March 19, and April 10, 2003. *Id*. at 56, 59. Treatment notes dated May 12, May 28, and June 10, 2003 continue to reflect that Claimant is not working but do not specify any work restrictions. *Id*. at 60-66. July 7 and August 1, 2003 treatment notes again show work restrictions of "Do not lift over 5 pounds. No repetitive bending, stretching or twisting. No prolonged standing, sitting longer than one hour with a five minute break to stretch." *Id*. at 69, 72. These physical limitations are clearly inconsistent with the requirements of Claimant's prior position as a "plant oiler" with IMC, EX 4,[11] and thus continue to support a finding of temporary total disability.

During his Deposition, Dr. Gari testified that he treated Claimant with epidural steroid injections and medication including muscle relaxers, sleeping pills, and pain medication. CX 17 at 594, 598. He also recommended, *inter alia*, facet injections, consultation with a neurosurgeon and neurologist, and an MRI of the lumbar and cervical spine which were never authorized. *Id*. at 598-99, 602. He reiterated his opinion that Claimant was unable to perform the job of "plant oiler" at IMC. *Id*. at 607. Dr. Gari's decision in March 2003 to change Claimant's work status from "unable to work" to "work with no lifting over five pounds, no repetitive bending, stretching, or twisting, no prolonged standing, and no sitting longer than one hour with a five-

[11] For example that position is classified as medium work involving exerting up to 50 pounds of force occasionally and 20 pounds of force frequently. EX 4 at 3. IMC has not offered Claimant any jobs to which he could return. Tr. 93.

minute break to stretch," was based on the fact that the facet injections he had been recommending were not going to be authorized. *Id*. at 613.

When reviewed both alone, and in conjunction with the medical reports of Dr. Dave, Dr. Gari's treatment records, testimony, and recommendations are consistent with Claimant's complaints and his physical limitations, and they thus support Claimant's assertion that he is unable to perform his prior job as a "plant oiler" with IMC.

Finally, Dr. John C. Baker examined Claimant at his attorney's request on August 18, 2003. CX 3. The examination lasted 25 to 35 minutes, Tr. 96, and is the most recent medical evidence relevant to Claimant's physical condition. Dr. Baker's findings included, *inter alia*, a notation that Claimant walked with an altered gait, listing forward and to the right. *Id*. at 75. He also noted 3+ paraspinal muscle spasms in the lumbar spine, difficulty heel-toe walking, flattening of the lumbar lordosis, and tight hamstring muscles bilaterally. *Id*. at 75-76. He reviewed x-rays of the cervical and lumbar spine which showed multiple level degenerative disc and facet disease. *Id*. at 76. He identified Claimant's February 8, 2002 injuries as an aggravating factor and contributing cause of his neck and back pain. *Ibid*. When deposed, he opined that Claimant was temporarily and totally disabled due to his February 8, 2002 work injuries. CX 16 at 547-48. Dr. Baker's findings and opinions are consistent with Claimant's credible testimony, and with the previously-described medical examinations and treatment records of Drs. Dave and Gari.[12]

Based on a review of all the evidence of record, including Claimant's credible testimony and the opinions of Drs. Dave, Baker, and Gari, I find Claimant has proven by a preponderance of the evidence that he has been incapable of performing his previous employment duties with Employer since July 29, 2002. I further find that Employer has failed to meet its burden of establishing the existence of suitable alternate employment. Claimant is thus entitled to temporary total disability compensation based on the injuries sustained while working for IMC on February 8, 2002.

C. Employer's Liability for Medical Benefits.

According to Employer, neither treatment nor further medical testing is reasonable or necessary with respect to Claimant's injuries. It asserts that "[t]here have never been any objective findings on examination regarding the cervical spine and diagnostics obtained thus far do not reveal any problems." Emp. Br. at 18. It further asserts that there is no evidence of neurological deficits in either Claimant's cervical or lumbar spine and there is no need for a lumbar MRI with contrast, facet joint injections, or a muscle stimulator. *Id*. at 18-19. Employer relies on the opinion of Dr. Finn, who examined Claimant once for "15 minutes, if that" in support of its denial of the treatment and testing sought by Claimant. *Ibid*.

Section 7(a) of the Act provides that "the employer shall furnish such medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of

[12] I note, in particular, that Dr. Gari's treatment records from August 1, 2003, reflect that Claimant was ambulating with the assistance of a cane. CX 2 at 71. Similar notations are recorded in prior treatment records dated March 4, March 19, June, 10, and July 7, 2003. *Id*. at 51, 55, 65, and 68.

recovery may require." 33 U.S.C. § 907(a). The Board has interpreted this provision to require that an employer pay all reasonable and necessary medical expenses arising from a workplace injury. *Dupre v. Cape Romaine Contractors, Inc.*, 23 BRBS 86, 94 (1989). A claimant establishes a *prima facie* case of entitlement to reimbursement for medical expenses when a qualified physician indicates that treatment is necessary for a work-related condition. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989); *Pirozzi v. Todd Shipyards Corp.*, 21 BRBS 294, 296 (1988); *Turner v. The Chesapeake and Potomac Telephone Co.*, 16 BRBS 255, 257-58 (1984). The test is whether the treatment is recognized as appropriate by the medical profession for the care and treatment of the injury. *Colburn v. General Dynamics Corp.*, 21 BRBS 219. 222 (1988); *Barbour v. Woodward & Lothrop, Inc.*, 16 BRBS 300 (1984). The employer bears the burden of showing by substantial evidence that the proposed treatment is neither reasonable nor necessary. *Salusky v. Army Air Force Exchange Service*, 3 BRBS 22, 26 (1975) (stating that any question about the reasonableness or necessity of medical treatment must be raised by the complaining party before the ALJ). Entitlement to medical services is never time-barred where a disability is related to a compensable injury. *Addison v. Ryan-Walsh Stevedoring Co.*, 22 BRBS 32, 36 (1989); *Mayfield v. Atlantic & Gulf Stevedores*, 16 BRBS 228 (1984); *Dean v. Marine Terminals Corp.*, 7 BRBS 234 (1977). Interest may be assessed on sums owed for medical services, whether the costs were initially borne by the claimant or the providers. *Ion v. Duluth, Missabe and Iron Range Railway Co.*, 31 BRBS 75, 80 (1997).

Claimant's treating and examining physicians have consistently recommended further diagnostic testing and treatment in light of Claimant's ongoing complaints of neck pain and low back pain which radiates into his legs. Dr. Dave examined Claimant on two occasions and recommended a cervical MRI, lumbar MRI with contrast, neurological testing and a neurological consultation. CX 1 at 9. His July 5, 2002 examination noted findings including numbness in the right fifth toe. CX 1 at 3. His October 28, 2002 examination revealed, *inter alia*, paraesthesias in the distribution of the L4 nerve root down the left lower extremity. CX 1 at 8. After re-reading the lumbar MRI previously taken, Dr. Dave concluded that the sensory changes Claimant was complaining of resulted from a frank disc herniation at L4/5. CX 1 at 9. Dr. Dave referred Claimant to Dr. Gari who treated Claimant over the course of several months for ongoing complaints of cervical and lumbar pain radiating into his legs. CX 2. Dr. Gari recommended, *inter alia*, facet injections. CX 2 at 25, 38, 41, CX 17 at 597-98. In January 2003, he recommended that Claimant consult a neurosurgeon and neurologist. CX 17 at 598. He also recommended an MRI of the lumbar spine. *Id*. at 599. It was his opinion that these tests would assist in determining what further treatment was reasonable and necessary. *Ibid*. Dr. Gari's medical partner also recommended a lumbar discogram to determine if Claimant's disc was compromised and causing pain. *Id*. at 600. A muscle stimulator was recommended to help with muscle spasms and to strengthen Claimant's back muscles. *Id*. at 600-01. Claimant was diagnosed in July 2003 with cervicalgia and radiculopathy in the upper extremities. *Id*. at 602. Dr. Baker examined Claimant on August 18, 2003 and noted, *inter alia*, that Claimant ambulated bent forward and listing to the right and had difficulty heel-toe walking. CX 3 at 75-76. He also noted that x-rays of the cervical and lumbar spine showed multiple level degenerative disc and facet disease. *Id*. at 76. He recommended, *inter alia*, an MRI of the cervical spine. *Ibid*. None of these physicians suggested that Claimant's ongoing symptoms were feigned or exaggerated.

As noted above, the only evidence offered by Employer in support of its assertion that the treatment and diagnostic testing requested by Claimant should not be authorized is the opinion of Dr. Finn who, at the time he was deposed, had no independent recollection of what medical records he reviewed in this case and admitted that his one-time examination of Claimant on August 28, 2002 lasted perhaps 15 minutes. EX 14 at 12, 36. He did not believe that a repeat MRI with contrast was necessary or appropriate since there had been no prior surgery or indication of an infection, osteomyelitis, or a bone tumor. *Id*. at 16. He similarly rejected the need for a neurological evaluation since there were no symptoms of radiculopathy when he examined Claimant on August 28, 2002. *Id*. at 17. He testified "if something has changed with his symptomology or if something has changed with his clinical examination after August 28, 2002, I would have no opinion [about the need for the recommended diagnostic testing.]" *Ibid.* The only medical evidence he specifically recalled reviewing before formulating his opinion was the report of a March 29, 2002 MRI of Claimant's lumbar spine. EX 14 at 14. He did not actually review the MRI film itself. *Ibid*.

In contrast to Dr. Finn's opinion, Claimant offers the opinions and treatment records outlined above of Dr. Dave, Dr. Gari, and Dr. Baker which span a period from July 5, 2002 to August 18, 2003. Drs. Baker and Dave, like Dr. Finn, are board-certified orthopedic surgeons. *See, e.g.*, EX 14 at 50, CX 3 at 77, CX 18 at 732. Dr. Gari is board-certified in anesthesiology, pain management, and medical examination. CX 17 at 618. All of Claimant's physicians believed further diagnostic testing was reasonable and necessary to properly evaluate and treat his ongoing complaints of back and neck pain. In light of the limited examination of Claimant by Dr. Finn, his inability to recall what records he reviewed before formulating his opinion, and his admission that a change in Claimant's symptomology or clinical examination after August 28, 2002 could alter his opinion, I find that opinion is entitled to less weight than the opinions of the equally qualified physicians who examined and treated Claimant for more than a year. As previously stated, I have also found Claimant's testimony about ongoing pain in his cervical and lumbar spine both credible and substantiated by the records of his treating and examining physicians. Based on these findings, I thus find that the specific diagnostic testing and medical treatment recommended by Drs. Dave, Gari, and Baker are reasonable and necessary, and that Employer is therefore liable for the costs related thereto.

VI. INTEREST

Although not specifically authorized in the Act, it has been accepted practice that interest at the rate of six percent per annum is assessed on all past due compensation payments. *Avallone v. Todd Shipyards Corp*., 10 BRBS 724 (1978). The Benefits Review Board and the federal courts have previously upheld interest awards on past due benefits to ensure that the employee receives the full amount of compensation due. *Santos v. General Dynamics Corp*., 22 BRBS 226 (1989); *Adams v. Newport News* Shipbuilding, 22 BRBS 78 (1989); *Smith v. Ingalls Shipbuilding*, 22 BRBS 26, 50 (1989); *Caudill v. Sea Tac Alaska Shipbuilding*, 22 BRBS 10 (1988); *Perry v. Carolina Shipping*, 20 BRBS 90 (1987); *Hoey v. General Dynamics Corp*., 17 BRBS 229 (1985); *Watkins v. Newport News Shipbuilding & Dry Dock Co.*, 8 BRBS 556 (1978), *aff'd in pertinent part and rev'd on other grounds sub nom*. *Newport News v. Director, OWCP*, 594 F.2d 986 (4th Cir. 1979). The Board has stated that inflationary trends in our economy have rendered a fixed six percent rate no longer appropriate to further the purpose of making

claimants whole, and held that "the fixed six percent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills . . . ." *Grant v. Portland Stevedoring Company*, 16 BRBS 267, 270 (1984), *modified on reconsideration*, 17 BRBS 20 (1985). Section 2(m) of Pub. L. 97-258 provided that the above provision would become effective October 1, 1982. This Order incorporates by reference this statute and provides for its specific administrative application by the district director. The appropriate rate shall be determined as of the filing date of this Decision and Order with the district director.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED that:

1. Employer and Carrier shall pay Claimant temporary total disability compensation benefits and interest from July 29, 2002 through the date of this order and continuing based on an average weekly wage of $675.84.

2. Employer and Carrier shall receive credit for all amounts of compensation previously paid to Claimant as a result of the work-related injuries identified herein.

3. Employer and Carrier shall pay to Claimant all reasonable and necessary medical benefits and interest to which he is entitled including the costs associated with the treatment and diagnostic testing recommended by Drs. Dave, Gari, and Baker as more particularly described herein.

4. Employer and Carrier shall pay Claimant's attorney fees and costs to be established by supplemental order.

5. The district director shall perform all calculations necessary to effect this order.

A

STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.